

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 00669

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

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1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bell Air</i>		c. LENGTH OF STAY IN 1b <i>6 Mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Convalescent Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>George E. Allison</i>		First <i>George</i>	Middle <i>E.</i>
4. DATE OF DEATH <i>January 7 1962</i>		Lost <i></i>	Month <i>January</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>July 22, 1880</i>		9. AGE (In years lost birthday) <i>81 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Quarryman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Harford Co. Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Samuel John Allison</i>	14. MOTHER'S MAIDEN NAME <i>Selina Morrison</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>008-07-8843</i>	17. INFORMANT <i>Robert A. Amos</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic CVDisease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>422.1</i>		(b) <i></i>	
		(c) <i></i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i>		(County) <i></i>	
(State) <i></i>			
21. I certify that I attended the deceased from <i>10-1, 1961</i> to <i>1-7, 1962</i> , that I last saw the deceased alive on <i>1-6, 1962</i> , and that death occurred at <i>34 M</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Bethel, Md</i>	
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		DATE SIGNED <i>1-7-62</i>	
PHYSICIAN'S NAME (Type) <i>Gerald C Palmer MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-10-1962</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Vernon cemetery</i>
22d. LOCATION (City, town, or county) <i>Whiteford, Md.</i>		(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Harkins</i>		ADDRESS <i>Bethel, Pa.</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 10 '62</i>
			24b. REGISTRAR'S SIGNATURE <i>James S. Timm</i>



TO HOSPITAL OR CLINIC: The law requires that the death certificate be executed within 24 hours after death. <sup>or 4 days</sup> may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

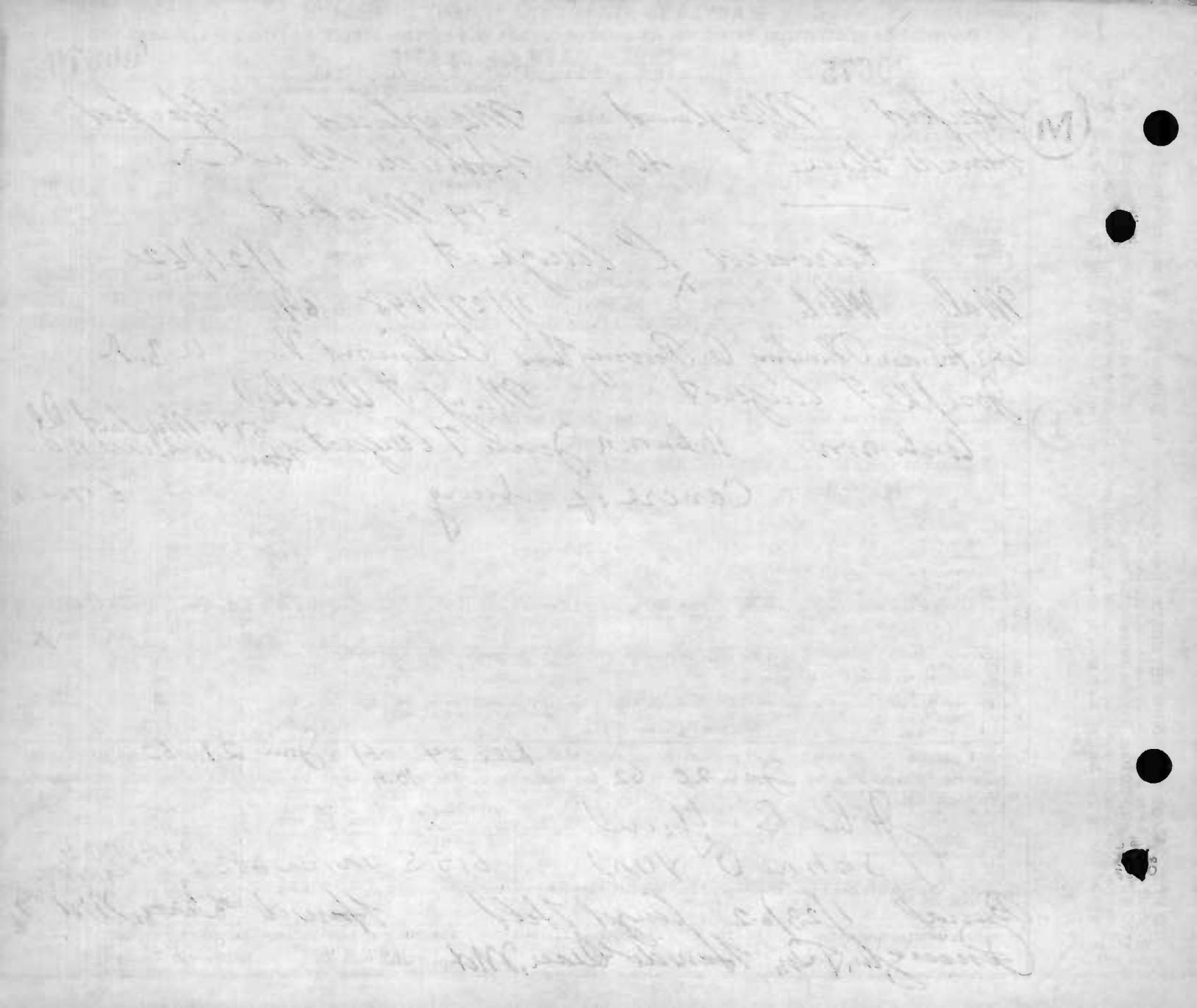
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

Item 9 Film G305 1/29/62 iwk

00675 00670

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) b. COUNTY	
<i>Harford Maryland</i>		<i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>40 yrs.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Edward F. August</i>			
4. DATE OF DEATH		Month	Day
<i>1/21/62</i>		19	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>Male</i>		<i>White</i>	<i>11/27/1898</i>
8. AGE (In years last birthday)		9. IF UNDER 1 YEAR Months Days Hours Min.	10. IF UNDER 24 HRS. Months Days Hours Min.
<i>63</i>		<i>63</i>	<i>64</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Cost. Foreman Plumbing</i>		<i>C. Provin Young</i>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Richmond Va</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Joseph F. August</i>		<i>Mary F. Walker</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service		16. SOCIAL SECURITY NO.	
<i>Unknown</i>		<i>165-7-1234</i>	
17. INFORMANT		Address	
<i>Unknown</i>		<i>314 Market St. Harford Chase, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>6 month</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		<i>Cancer of lung</i>	
(b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 24, 1961</i> to <i>Jan 21, 1962</i> that (I) (we) last saw the deceased alive on <i>Jan 20, 1962</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED	
22e. SIGNATURE <i>John D. Yun</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>John D. Yun</i>		22d. ADDRESS <i>615 S. UNION AV 1 HARFORD CHASE</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/23/62</i>	23c. NAME OF CEMETERY OR Crematory <i>Angel Hill</i>
23d. LOCATION (City, town or county) (State) <i>Harford Chase, Md. 17</i>		25a. REC'D BY REGISTRAR <i>JAN 25 '62</i>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Frederick J. Yun, Harford Chase, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	
ADDRESS		DATE	



TO HOSPITAL OR ATTENDANT: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDANT  
TO FUNERAL DIRECTOR

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04585

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md</b>		b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harve de Grace</b>		c. LENGTH OF STAY IN 1b <b>11 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harve de Grace</b>		d. STREET ADDRESS <b>617 N Stokes St.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Baby Boy Bancroft</b>		First	Middle	Last	4. DATE OF DEATH <b>JAN. 26</b>	Month	Day	Year <b>1962</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-26-62</b>	9. AGE (In years last birthday) yrs. <b>11</b>	IF UNDER 1 YEAR Months <b>11</b>	IF UNDER 24 HRS. Hours <b>11</b>	Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Herbert Maynard Bancroft</b>		14. MOTHER'S MAIDEN NAME <b>Linda Marie DuBree</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Haem</b>								
754.5 DUE TO <b>1</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____								
DUE TO <b>1</b>								
DUE TO <b>1</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1-26</b> 19 <b>62</b> , to <b>1-26</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1-26</b> 19 <b>62</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.								
22a. SIGNATURE <b>Bancroft</b>					M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>1-27-62</b>		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1-28-62</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Harford Mem Hosp.</b>		23d. LOCATION (City, town, or county) (State) <b>Harve de Grace Md</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry R. Cilly</b>		ADDRESS <b>Administrator</b>		25a. REC'D BY REGISTRAR DATE <b>APR 10 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>		
2-003431								

62241

RECEIVED  
CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00676

## CERTIFICATE OF DEATH

Reg. Dist. No. 111671

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. LENGTH OF STAY IN 1b 28 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford, Rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Virginia		First	Middle	Last	4. DATE OF DEATH Jan. 8	Month	Day	Year
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1876		9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pylesville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Amos			14. MOTHER'S MAIDEN NAME McComas					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Emma Barton York - Whiteford, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Cardiac Decompensation</i> 44111 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Arterio Sclerotic C-V Disease</i> DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Delta	(County) Penn	(State) Penn
21. I certify that I attended the deceased from _____, 1945, to _____, 1962, that I last saw the deceased alive on _____, 1962, and that death occurred at _____, M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Josiah A. Hunt</i>	ADDRESS (Street, city or town, state) Delta, Pa. 1962							
PHYSICIAN'S NAME (Type) <i>Josiah A. Hunt, MD</i>	DATE SIGNED 1/9/62							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-11-1962	22c. NAME OF CEMETERY OR CREMATORIUM Slate Ridge			22d. LOCATION (City, town, or county) Delta, Penna.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Hopkins</i>		ADDRESS Delta, Penna.		24a. REC'D BY REGISTRAR JAN 10 '62		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00677

## CERTIFICATE OF DEATH

00672

## 1. PLACE OF DEATH

e. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Haure de Grace

c. LENGTH OF STAY IN 1b

3 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Harford Memorial Hosp.

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATHMonth Day Year  
1 - 17 1962

5. SEX

6. COLOR OR RACE

Male

White

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Amos G. Bechtel

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give war orders of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

1 - 14 - 62

9. AGE (In years  
less birthday)

yrs.

Months

Days

Hours

Min.

12. CITIZEN OF WHAT COUNTRY?

USA

11. BIRTHPLACE (County &amp; State, or foreign country)

Harford County - Md

14. MOTHER'S MAIDEN NAME

Anne (Dunn) Bechtel

Address

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

&gt;&gt;6X

DUE TO

Conditions, if any, which  
give rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

Prematurity

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour a.m.  
p.m.20d. INJURY OCCURRED  
While at work  Not While at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ..... to ..... to ..... that (I) (we) last  
saw the deceased alive on ..... and that death occurred at ..... A.M. from the causes and on the date stated above.

22a. SIGNATURE

Theodore H. Kauer

M.D.

ATTENDING  
PHYS. MED.  
DIRECTOR STAFF  
PHYS. 22b. DATE  
SIGNED22c. PHYSICIAN'S  
NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

CREMATION

1-17-62

23c. NAME OF CEMETERY OR CREMATORIUM

HARFORD Memorial Hospital

23d. LOCATION (City, town or county)

HAURE de GRACE, MD

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Harford Memorial Hospital. Henry R. Muller - Administrator

DATE

Arthur S. Kauer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Please be ready by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If any remains, be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

B

2171363122

JAN 25 '62

1059  
103 miles east of town  
20 miles west of town  
E 20° 45' N 103° 45' W  
AZ 100-1000000  
Water (wind) sand

M

1

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00678 00678

## 1. PLACE OF DEATH

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Harve de Grace

c. LENGTH OF STAY IN 1b

1 day

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Harford Memorial Hospital

3. NAME OF  
DECEASED  
(Type or print)

First Middle

Lexgra

d. STREET ADDRESS

Bel Air

Last

Box 336 R.F. #1

e. IS RESIDENCE  
ON A FARM?YES  NO 

e. SEX

Female

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

8. DATE OF BIRTH

Sept. 29, 1878

9. AGE (In years  
last birthday)

83 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

none

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (County &amp; State, or foreign country)

Harford Co., Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.,

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

George T. Hanna

Carrie Hopkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

James L. Briney

Bel Air, R.D., Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

4522 DUE TO

Conditions, if any, which  
gave rise to immediate cause{ (a) stating the underlying  
cause last. } (b)

DUE TO

cause last. (c)

Acute Pulmonary Oedema  
Atherosclerotic CVD disease 8 yrsINTERVAL BETWEEN  
ONSET AND DEATH

30 mins

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour a.m. While at work  Not White   
p.m. 19 at work  at work 20d. INJURY OCCURRED  
While at work  Not White   
at work  at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January 19, 1962, to January 19, 1962, that (I) (we) last saw the deceased alive on January 18, 1962, and that death occurred at Bel Air, M., from the causes and on the date stated above.

22a. SIGNATURE

M.D.

22b. DATE  
SIGNED22c. PHYSICIAN'S  
NAME (Type)

Ralph Horky

1/18/62

23a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

23b. DATE THEREOF

Jan. 21, 1962

23c. NAME OF CEMETERY OR CREMATORIAL

Rock Run

23d. LOCATION (City, town or State)

Harford Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Howard K. McComas &amp; Son

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Jan. 23, 1962

Howard K. McComas &amp; Son

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Please be ready for the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If page 3 is not filled in by the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death, be filed with the State Dept. of Health.

VR A15 (4)  
15M 9/60



1  
FOR STATE  
HEALTH DEPT.  
M

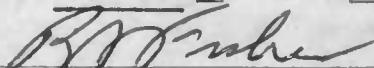
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00679

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

001674

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN lb 3 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		d. STREET ADDRESS 07X2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital								
3. NAME OF DECEASED (Type or print) CAROL		First	Middle	Last	4. DATE OF DEATH BROWN	Month 1	Day 14	Year 19 62
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 13, 1938	9. AGE (In years last birthday) 23 86 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME C. Calvert Evans		14. MOTHER'S MAIDEN NAME Dorothy DeCecco						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT C. Calvert Evans, Vienna, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 642.3		DUE TO Intracerebral hemorrhage						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO Eclampsia with liver necrosis						
		(c) DUE TO Pregnancy						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cambridge, Md.	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.		DATE SIGNED 1-15-62		
ACTUAL SIGNATURE 				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.				Address (Street, city, town, or county) Cambridge, Md.				
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 17, 1962	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park	22d. LOCATION (City, town, or country) Cambridge, Md.	(State)			
23. FUNERAL DIRECTOR Kenneth P. Thomas		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR JAN 19 '62	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
VS. A15ME 5M 9/60				DATE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please be ready by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00680

**CERTIFICATE OF DEATH**

00680

**1. PLACE OF DEATH**

a. COUNTY

*Harford*

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

*R.D.1 Bel-air*

c. LENGTH OF STAY IN 1b

*Lifetime*

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

*Box 370 R.D.1 Bel-air*

**3. NAME OF DECEASED  
(Type or print)**

First

Middle

*LEON*

*BROWNE*

Last

**4. DATE OF DEATH**

Month

Dey

Year

*1*

*8*

*1962*

**5. SEX**

*Male*

**6. COLOR OR RACE**

*Negro*

**7. MARRIED**  **NEVER MARRIED**

**WIDOWED**

**DIVORCED**

**B. DATE OF BIRTH**

*Sept. 13, 1890*

**9. AGE (in years last birthday)**

*71 yrs.*

**10. IF UNDER 1 YEAR**

**Months**  **Days**

**Hours**  **Min.**

**10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)**

*Labor (Retired) Aberdeen Young Guard*

**13. FATHER'S NAME**

*Mr. Edward Browne*

**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)**

*— — — — —*

**16. SOCIAL SECURITY NO.**

*215-12-0438*

**17. INFORMANT**

*Mrs Beatrice Hoff Browne*

**12. CITIZEN OF WHAT COUNTRY?**

*U.S.A.*

**Address**

*Box 370 R.D.1 Bel-air, Md.*

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (e) *Bronchiogenic carcinoma with metastases*

162.1 DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last. (b)

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

**PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)**

**19. WAS AUTOPSY PERFORMED?**

**YES**  **NO**

**20a. ACCIDENT WAS UNDERLYING**  **20b. DESCRIBE HOW INJURY OCCURRED** (Enter nature of injury in Part I or Part II of item 1b.)  
OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year  
Hour e.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
p.m. 19 While Not White at work  at work

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from *11/29*, 1961, to *1/18*, 1962, that (I) (we) last saw the deceased alive on *1/6*, 1962, and that death occurred at *11:15 P.M.* from the causes and on the date stated above.

22e. SIGNATURE *George T. Stansbury* M.D. 22b. DATE SIGNED *11/16/62*

22c. PHYSICIAN'S NAME (Type) *George T. Stansbury* ATTENDING PHYS.  MED. DIRECTOR  STAFF PHYS.

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF *1-12-62* 23c. NAME OF CEMETERY OR CREMATORIAL *Asbury Methodist* 23d. LOCATION (City, town or county) (State) *Churchville, Harford, Md.*

24 FUNERAL DIRECTOR'S SIGNATURE *Elmer E. Bullock* ADDRESS *House of Grace, Md.* 25e. REC'D BY REGISTRAR *DATE JAN 15 '62* 25b. REGISTRAR'S SIGNATURE *Arthur S. Hause*

0-000

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I

A 2-35 Individually wrapped (stuffed) meat  
and well wrapped well wrapped or wrapped meat  
while it is wrapped you will be well wrapped

1  
FOR STATE  
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00681

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00676

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Harford		MARYLAND		a. STATE Ma	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Bel Air	
Bel Air		2 months		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
608 S Main St		1608 S Main St		e. DATE OF DEATH Month Day Year January 27 1962	
3. NAME OF DECEASED (Type or print)		First Middle Last		9. AGE (In years last birthday) IF UNDER 1 YEAR yrs. Months Deys Hours Min.	
Gordon James Caudill				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
5. SEX M		6. COLOR OR RACE W		10b. KIND OF BUSINESS OR INDUSTRY None	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11-25-61		11. BIRTHPLACE (State or foreign country) Maryland	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		14. MOTHER'S MAIDEN NAME Maria Guercio	
13. FATHER'S NAME Gene R. Caudill		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank or date of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Mr. Gene R. Caudill		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address 608 S. Main St. Bel Air, Md.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) DUE TO cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 20d. INJURY OCCURRED While Not While p.m. 19 at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-27-62	
ACTUAL SIGNATURE: Gerald C Palmer		EXAMINER'S NAME (Type) Gerald C Palmer M.D.		Address (Street, city, town, or county) Hickory, Harf. Co., Maryland	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial 1/29/62		22f. DATE THEREOF St. Ignatius Cem.		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR Joseph W. Foster		ADDRESS W. Broadway & Williams Bel Air, Maryland		24e. REC'D BY REGISTRAR JAN 29 '62 24f. REGISTRAR'S SIGNATURE Arthur S. Haas	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 00677

1. PLACE OF DEATH o. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.		b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford - Rural		c. LENGTH OF STAY IN 1b 62 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Whiteford				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Flintville Rd.		d. STREET ADDRESS Flintville Rd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) STEPHEN		First	Middle	Lost	4. DATE OF DEATH Jan. 25,	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 26, 1899	9. AGE (In years lost birthday) 62 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Whiteford, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Sidney Cooper		14. MOTHER'S MAIDEN NAME Mary M. Stewart						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-36-8091		17. INFORMANT Mrs. Helen L. Cooper, Delta R.D., Pa.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Hepatic failure				INTERVAL BETWEEN ONSET AND DEATH 3 days		
153.9 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO (b) Carcinoma of bowel with metastasis				2 years		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from Sept 1961, to 25 Jan 1962, that I last saw the deceased alive on 25 Jan 1962, and that death occurred at 12:00 P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE Edwin W. Whiteford, M.D.						DATE SIGNED Jan. 25, 1962		
PHYSICIAN'S NAME (Type) Edwin W. Whiteford								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 28, 1962		22c. NAME OF CEMETERY OR CREMATORIAL Slate Ridge		22d. LOCATION (City, town, or county) Delta		(State) Penns.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Hardin		ADDRESS Delta, Penna.		24a. REC'D BY REGISTRAR JAN 29 '62		24b. REGISTRAR'S SIGNATURE John S. Knott		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate may be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be done by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00683

Item 4 Film G306

CERTIFICATE OF DEATH

00678

1. PLACE OF DEATH

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural - Bel air

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF DECEASED  
(Type or print)

First Catherine Weber Creswell

Middle

Last

4. DATE  
OF  
DEATH

January 24

Year  
19 62

5. SEX

Female w

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED

8. DATE OF BIRTH

Oct 4 1875

9. AGE (In years  
last birthday)

86

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife Home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Baltimore, Md

U.S.

13. FATHER'S NAME

Edward Weber

14. MOTHER'S MAIDEN NAME

Louisa Ohlgart Weber

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give rank & dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs Jean Wright, Bel air, Md

INTERVAL BETWEEN  
ONSET AND DEATH

10 min

2 YEARS

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

CORONARY OCCUSION

420.1  
Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

DUE TO

(b)

DUE TO

(c)

ADVANCED ARTERIOSCLEROSIS

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour e.m.

p.m.

While  
at work

Not While  
at work

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

21. I certify that (I) (this hospital) attended the deceased from JAN 19 59 to JAN 24 1962, that (I) (we) last saw the deceased alive on DEC 15 1961, and that death occurred at 3 P.M. from the causes and on the date stated above.

22e. SIGNATURE

H. P. Sidwell M.D.

M.D.

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

22b. DATE  
SIGNED

26 JAN '62

22c. PHYSICIAN'S  
NAME (Type)

H. P. Sidwell M.D.

22d. ADDRESS

401 FRANKLIN ST. BEL AIR, MD.

23e. BURIAL, CREMATION,  
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town or county)

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Archers Funeral Home

ADDRESS

Benson Md

25a. REC'D BY REGISTRAR

JAN 31 '62

25b. REGISTRAR'S SIGNATURE

Robert S. Thomas

2200

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00684

## CERTIFICATE OF DEATH

00679

## 1. PLACE OF DEATH

e. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bel-Air

c. LENGTH OF STAY IN lb

Lifetime

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Route #1 Box 244

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

John

F. Daugherty

5. SEX

e. COLOR OR RACE

Male

Negro

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

Nov. 26, 1881

about last birthday

80 yrs.

4. DATE  
OF  
DEATH

Month

Jan.

Day

26

Year

1962

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Army Chemical Center

11. BIRTHPLACE (County &amp; State, or foreign country)

Harford County, Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

George S. Daugherty

14. MOTHER'S MAIDEN NAME

No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service)

no

16. SOCIAL SECURITY NO.

218-18-0622

17. INFORMANT

Mrs. Frances E. Williams

Address

441 Box 244

Bel-Air, Md.

INTERVAL BETWEEN  
ONSET AND DEATH

4 days

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)332 X  
Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

Cerebral thrombosis

Cerebral arteriosclerosis

10 years

DUE TO  
(b)DUE TO  
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 

20a. MEDICAL CERTIFICATION

20c. TIME OF INJURY Month, Day, Year

Hour e.m.

20d. INJURY OCCURRED

p.m.

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)While at work  Not While at work 

20f. (City or town)

(County)

(State)

19

21. I certify that (I) (this hospital) attended the deceased from Jan. 23, 1962 to Jan. 26, 1962, that (I) (we) last

saw the deceased alive on Jan. 23, 1962, and that death occurred at 1 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Charles Richardson Jr.

M.D.

ATTENDING PHYS.

M.D.

DIRECTOR

STAFF

PHYS.

22b. DATE  
SIGNED

Jan. 27, 1962

22c. PHYSICIAN'S NAME (Type)

Charles Richardson Jr.

M.D.

ATTENDING PHYS.

M.D.

DIRECTOR

STAFF

PHYS.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

(State)

Burial 1-30-1962 Clarks Chapel Cemetery Bel-Air, Harford Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

(State)

Arthur S. Kraus

15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Please be advised by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

M

woodpecker  
inches will be saved

and the rest of the wood  
will be saved, with 75% of the wood

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00685 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00680

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>3 yrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>County Home</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Hattie E. De Moul</i>		First <i>Hattie</i>	Middle <i>E</i>
4. DATE OF DEATH <i>Times 21-4-25 1962</i>	Last <i>De Moul</i>	Month <i>April</i>	Day <i>25</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>Widow</i>	8. DATE OF BIRTH <i>5/15/1886</i>
9. AGE (In years last birthday) <i>95 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Sum. P. R.</i>	11. BIRTHPLACE (State or foreign country) <i>Harford, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John Crawford</i>	14. MOTHER'S MAIDEN NAME <i>Mary Butler</i>	Address <i>135 Wilson St. Harford, Md.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>Unknown</i>	17. INFORMANT <i>Hammond Mull</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Pneumonia</i>
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. <i>492X</i>	DUE TO  (b)  (c)	DUE TO  (b)  (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Gerald C Palmer</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Baltimore, Md.</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>1-25-62</i>
EXAMINER'S NAME (Type) <i>Gerald C Palmer</i>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Angel Hill</i>	22a. REC'D BY REGISTRAR <i>JAN 30 '62</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>
22. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/28/62</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Angel Hill</i>	22d. LOCATION (City, town, or country) (State) <i>Harford, Md.</i>
23. FUNERAL DIRECTOR <i>Parsons &amp; Son Harford, Md.</i>	ADDRESS <i>Parsons &amp; Son Harford, Md.</i>	24a. DATE	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the funeral director or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.FOSTER FUNERAL HOME  
W. BROADWAY & WILLIAMS BEL AIR, MD.

00686

## CERTIFICATE OF DEATH

Reg. Dist. No. 00681

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Fallston</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Fallston</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bel Air Road</b>			d. STREET ADDRESS <b>Bel Air Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Edward Clarence Dietz</b>			First	Middle	Last	4. DATE OF DEATH January 3, 1962	Month	Day	Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 12, 1882</b>			9. AGE (In years lost birthday) <b>79</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Gas Mask Factory</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Philip Dietz</b>			14. MOTHER'S MAIDEN NAME <b>Eleanor J. Levering</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>UNKNOWN</b>			17. INFORMANT (Neice) <b>Mrs. Joan D. Dalton</b>	Address <b>R.F.D. #2, Box 117 Fallston, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis, recurrent</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>many years</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <b>Carcinoma of prostate (arrested by hormone therapy); mild Diabetes mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Kingsville, Balto. Co., Md.</b>		(County)	(State)	
21. I certify that I attended the deceased from <b>NOVEMBER 14, 1961</b> , to <b>JANUARY 3, 1962</b> , that I last saw the deceased alive on <b>Dec. 29, 1961</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above.										
ADDRESS (Street, city or town, state) <b>115 Fulford Ave.</b>										
ACTUAL SIGNATURE <b>Paul S. Stonesifer, Jr.</b>	DATE SIGNED <b>1/3/62</b>									
PHYSICIAN'S NAME (Type) <b>PAUL S. STONESIFER JR.</b>	BEL AIR, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/6/62</b>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>St. Johns Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Kingsville, Balto. Co., Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Foster</b>			24a. REC'D BY REGISTRAR <b>DATE JAN 5 '62</b>			24b. REGISTRAR'S SIGNATURE <b>1/7/62</b>				

100

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 00682

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Bel Air		c. LENGTH OF STAY IN lb 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air 32	
3. NAME OF DECEASED (Type or print) Priscilla		First Forwood	Middle Last Month Day Year January 13, 1962
4. DATE OF DEATH	Month	Day	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1872
9. AGE (In years last birthday) 89	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. DAYS	12. IF UNDER 24 HRS. Hours
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian	10b. KIND OF BUSINESS OR INDUSTRY Public Library	11. BIRTHPLACE (State or foreign country) Harf. Co., Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME William S. Forwood	14. MOTHER'S MAIDEN NAME Rebecca Glenn		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. ----	17. INFORMANT Mrs. Henry Weisheit	18. CHURCHVILLE ROAD R.D. BelAir, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> 425 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-10</u> , 19 <u>62</u> , to <u>1-13</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>1-12</u> , 19 <u>62</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <u>Gerald C. Palmer</u>	DATE SIGNED 1/13/62		
PHYSICIAN'S NAME (Type) Gerald C. Palmer, M.D.	S. Main St., Bel Air, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/16/62	22c. NAME OF CEMETERY OR CREMATORIUM St. Ignatius Cem.	22d. LOCATION (City, town, or county) Hickory, Harford Co., Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>	ADDRESS W. Broadway & Williams St. Bel Air, Maryland	24a. REC'D BY REGISTRAR DATE JAN 16 '62	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: An application for a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Fill in page 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00688

CERTIFICATE OF DEATH

00683

1. PLACE OF DEATH

a. COUNTY

HARFORD

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

HARFORD

c. LENGTH OF STAY IN 1B

37 DAYS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

HARFORD Memorial Hosp.

First  
3. NAME OF  
DECEASED  
(Type or print)

Middle

NENA Dobbins GARDNER

Last

4. DATE  
OF  
DEATH

Month Day Year  
JANUARY 23 1962

5. SEX

FEMALE

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

June, 25, 1870

9. AGE (In years  
last birthday)

91 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

none

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (County & State, or foreign country)

TENNESSEE

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Archibald Dobbins

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

none

17. INFORMANT

George H. Gardner

Address

Abingdon Maryland

18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

422.1 DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last. (b)

DUE TO

(c)

Uremia & inanition

Gangrenous left thigh

ASCVD

INTERVAL BETWEEN  
ONSET AND DEATH

7 days

12 days

years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Carcinoma of esophagus, lower 1/3

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Give nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 19

20d. INJURY OCCURRED  
White Not White  
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour p.m.

21. I certify that (I) (this hospital) attended the deceased from 12/23/61 to 1/23/62, that (I) (we) last

saw the deceased alive on 1/23/62, and that death occurred at 3:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE

EDW Grigoleit MD

M.D.

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

22b. DATE  
SIGNED

1/23/62

22c. PHYSICIAN'S  
NAME (Type)

A.W. GRIGOLEIT MD

22d. ADDRESS

608 S. Union Ave. Harford, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial Jan. 25, 1962

23b. DATE THEREOF

St. Mary's Episcopal

23c. NAME OF CEMETERY OR CREMATORIAL

Emmorton, Harford, Maryland.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Howard K. McComas & Son

ADDRESS

Abingdon, Md.,

25a. REC'D BY REGISTRAR

JAN 26 1962

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

(State)

## 1. Old Compt.

2000-2001

an add-on to the CTD

### ANSWER

11

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00689

## CERTIFICATE OF DEATH

Reg. Dist. No.

00684

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in by the funeral director, who should be present at the time of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(RURAL) BEL AIR</b>		c. LENGTH OF STAY IN 1b <b>32 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RR#3 Box 30</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b>	First <b>THELMA</b>	Middle <b>HAMILTON</b>	Last <b>JANUARY 16 1962</b>
4. DATE OF DEATH	Month	Day	Year
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>JULY 24, 1907</b>
		DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) <b>54</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME MAKER</b>	
11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALFRED JAMES JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY EFFIE SPARKS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. —	
17. INFORMANT Address <b>ROLAND HAMILTON - Box 30 RR#3, BEL AIR.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>CARCINOMA RT. BREAST WITH GENERALIZED 21 MOS</b>		DUE TO (b) <b>METASTASES TO VERTEBRAE, LUNGS AND ABDOMEN</b>	
DUE TO (c) <b>METASTASES TO VERTEBRAE, LUNGS AND ABDOMEN</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>OCT 1961</b> to <b>JAN 16, 1962</b> that I last saw the deceased alive on <b>JAN 14, 1962</b> , and that death occurred at <b>8:00 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>307 HICKORY AVE</b>	
ACTUAL SIGNATURE <b>Philip W. Heuman</b>		DATE SIGNED <b>JAN 16, 62</b>	
PHYSICIAN'S NAME (Type) <b>PHILIP W. HEUMAN, M.D.</b>		M.D. <b>BEL AIR, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/18/62</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Bakers Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Aberdeen, R.D. 2, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Tarring</b>		24a. ADDRESS <b>Tarring Funeral Home</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
		DATE <b>JAN 22 '62</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00690 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

111685

1. PLACE OF DEATH

a. COUNTY

Hagerstown

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Aberdeen

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

RD 2 Box 401A

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

Susie Sabo Hammond

4. DATE  
OF  
DEATH

Month

Day

Year

January 17 1962

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED

B. DATE OF BIRTH

WIDOWED

DIVORCED

April 15, 1897

9. AGE (In years  
at birth)

61

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Waiter-Gypsy retired A.P. Goot.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Sabo.

14. MOTHER'S MAIDEN NAME

Untuocore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Marvin L. Hammond, Sr. Aberdeen 2nd

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

916.0 3rd degree burns body

INTERVAL BETWEEN  
ONSET AND DEATH

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Caught dress on fire

20c. TIME OF INJURY Month, Day, Year  
Hour  1-17 62  
p.m.  While at work  Not While at work

20d. INJURY OCCURRED  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

A Home Aberdeen Maryland

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
SIGNATURE

Donald C Palmer Bel Air Md

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S  
NAME (Type)

Gerald C Palmer

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

1-17-62

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CEMETORY

22d. LOCATION (City, town, or country) (State)

Fairmount, Marion Co., W. Va.

23. FUNERAL DIRECTOR

Tarring Funeral Home

John T. Tarring - Aberdeen, Md.

24a. REC'D BY REGISTRAR JAN 22 '62

DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00691

## CERTIFICATE OF DEATH

00686

## 1. PLACE OF DEATH

e. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Havre De Grace

c. LENGTH OF STAY IN 1b

D O A

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Harford Memorial Hospital

3. NAME OF  
DECEASED  
(Type or print)First  
DavidMiddle  
StephenLast  
Jackson4. DATE OF  
DEATH

Jan. 27

19 62

## 5. SEX

Male

## 6. COLOR OR RACE

White

## 7. MARRIED

 NEVER MARRIED

## 8. DATE OF BIRTH

 X

Nov. 23, 1906

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Auto Mechanic

## 11b. KIND OF BUSINESS OR INDUSTRY

Garage

## 11. BIRTHPLACE (County &amp; State, or foreign country)

Maryland, Cecil Co. U S A

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME

David C. Jackson

## 14. MOTHER'S MAIDEN NAME

Lulu

Gilbert

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

219-05-5249

## 17. INFORMANT

Mrs Edna Todd, Perryville, Md. Rural

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

416X

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

DUE TO

(b)

DUE TO

(c)

Ventricular Standstill  
Rheumatic and Arteriosclerotic heart  
DiseaseINTERVAL BETWEEN  
ONSET AND DEATH

sudden

5 years.

## MEDICAL CERTIFICATION

## 19. WAS AUTOPSY PERFORMED?

YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour  
e.m. \_\_\_\_\_  
p.m. \_\_\_\_\_20d. INJURY OCCURRED  
While at work  Not White   
at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 15th, 1954 to Jan. 27, 1962, that (I) (we) last saw the deceased alive on Jan. 27th, 1962, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

## 22a. SIGNATURE

Edward C. Loo, M.D.

ATTENDING PHYS.  MED. DIRECTOR  STAFF PHYS. 

1/27/62

## 22c. PHYSICIAN'S NAME (Type)

Edward C. Loo, M.D.

22d. ADDRESS

23e. BURIAL, CREMATION, DATE THEREOF

BURIAL (Specify)

1-31-1962

## 23c. NAME OF CEMETERY OR CREMATORIAL

Asbury Cemetery

## 23d. LOCATION (City, town or county) (State)

Port Deposit, Md. Rural

## 24. FUNERAL DIRECTOR'S SIGNATURE

Leea, Patterson &amp; Son, Perryville, Md.

## ADDRESS

## 25a. REC'D BY REGISTRAR

DATE JAN 30 '62

## 25b. REGISTRAR'S SIGNATURE

Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. And in any event, within 72 hours after death be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)  
15M 9/60

First

Issue

1970-1971

600

STUDY OF GEMINI

60 min. reading material from

1971 necessary material 60 min.

1971 reading material 60 min.

60 min. reading material 60 min.

60 min. reading material 60 min.

STUDY OF GEMINI 60 min. reading material

1971 reading material 60 min.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00692 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00687

1. PLACE OF DEATH a. COUNTY		Item 7 Film 0311		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)							
Harford		MARYLAND		a. STATE	b. COUNTY						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		Harford							
Edgewood				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		Edgewood							
Pine Street		Pine st.		d. STREET ADDRESS							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH						
Edgar Robert Lamb					Jan 25 1962						
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 48 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.				
M		W	SINGLE	Apr. 26, 1913	48 yrs.	Months Days	Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Soldier (Ret)		U.S. Army		Scranton, Pa.,		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Margaret Robacker		Address					
Frank Lamb											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)					
yes WW1		112-07-6424		William Lamb, 1165 Mary St., Elizabeth, N.J.,		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture Oesophagel Varix S81.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis liver (c) DUE TO					
						INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
				Hour a.m.	While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	19					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or country)		22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE	
ACTUAL SIGNATURE		20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	
EXAMINER'S NAME (Type)		20f. (City or town)		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(County)		(State)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or country)		22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE	
Burial		Jan. 23, 1962		Post Cemetery		Army Chemical Center		DATE JAN 25 '62		Md.,	
23. FUNERAL DIRECTOR		ADDRESS									
Howard K. McComas & Son		Abingdon, Md.,									

M

20

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 00653 01684

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BEL AIR</b>		c. LENGTH OF STAY IN 1b <b>5 YRS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>206 CHURCHVILLE Rd</b>		e. STREET ADDRESS <b>206 CHURCHVILLE Rd</b>			
3. NAME OF DECEASED (Type or print) <b>HELEN ARMINA LEWIS</b>		First <b>HELEN</b>	Middle <b>ARMINA</b>		
4. DATE OF DEATH <b>JANUARY 30 1962</b>	Month <b>JANUARY</b>	Day <b>30</b>	Year <b>1962</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 7, 1885</b>		
9. AGE (In years lost birthday) <b>76 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>	11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>WILLIAM J. ADAMS</b>	14. MOTHER'S MAIDEN NAME <b>EMMA. WELKER</b>	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>FRANK HALL LEWIS, BEL AIR, MD</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA LARGE BOWEL WITH</b> DUE TO (c) <b>GENERALISE METASTASES</b>	INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>  APPROX <b>3 1/2 YRS.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <b>—</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. (City or town) <b>—</b>	(County) <b>—</b>	(State) <b>—</b>
21. I certify that I attended the deceased from <b>JULY</b> , 19 <b>60</b> , to <b>JAN 30</b> , 19 <b>62</b> that I last saw the deceased alive on <b>JAN 28</b> , 19 <b>62</b> , and that death occurred at <b>11:00P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>307 HICKORY AVE</b> DATE SIGNED <b>JAN 30, 1962</b>					
ACTUAL SIGNATURE <b>Philip W. Heuman</b>	M.D.	22. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>FEB. 3, 1962</b> 22c. NAME OF CEMETERY OR CREMATORIAL <b>Friends Cemetery</b> 22d. LOCATION (City, town, or county) <b>FALLSTON, HARFORD CO., MARYLAND</b> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Foster</b>	ADDRESS <b>W. BROADWAY AND WILLIAMS ST. BEL AIR, MARYLAND</b>	24a. REC'D BY REGISTRAR <b>FEB 2 '62</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the Hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

STATEMENT OF DEATH

DECEASED PERSON'S NAME: LEWIS HARRIS

DATE OF DEATH: DEC 11 1952

PLACE OF DEATH: HOSPITAL

CAUSE OF DEATH: HEART DISEASE

NAME OF DOCTOR: DR. RICHARD

CERTIFYING PHYSICIAN

I, the undersigned, do hereby certify that the above named deceased person died in the State of New York on the date and place hereinabove stated.

I further certify that I am a physician and surgeon, and that I have examined the deceased person, and that I am acquainted with the cause of death.

I further certify that the deceased person died in the State of New York on the date and place hereinabove stated.

I further certify that I am a physician and surgeon, and that I have examined the deceased person, and that I am acquainted with the cause of death.

I further certify that the deceased person died in the State of New York on the date and place hereinabove stated.

I further certify that I am a physician and surgeon, and that I have examined the deceased person, and that I am acquainted with the cause of death.

I further certify that the deceased person died in the State of New York on the date and place hereinabove stated.

I further certify that I am a physician and surgeon, and that I have examined the deceased person, and that I am acquainted with the cause of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be attached to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00654

**CERTIFICATE OF DEATH**

00689

1.		PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)									
a. COUNTY		Harford		e. STATE Maryland									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Havre de Grace		b. COUNTY Harford									
c. LENGTH OF STAY IN 1b		1 day		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Harford Memorial Hosp.		X Bel Air (RURAL)									
3. NAME OF DECEASED (Type or print)		First	Middle	d. STREET ADDRESS		Lynch		4. DATE OF DEATH	Month	Day	Year	a. IS RESIDENCE ON A FARM?	
Baby		Boy		1 RT 1 Box 467				JANUARY	8	19	62	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX		6. COLOR OF RACE	7. MARRIED	<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years least birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
Male		W	WIDOWED	<input type="checkbox"/>		JANUARY 7, 1962		Years	Months	Days	Hours	Months	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
None		None		Maryland		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MÄIDEN NAME											
Paul Leroy Lynch		Peggy Louise Rodahaver											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
No				Mother		Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Prematurity - 32-33 weeks gestation											
776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause least.		DUE TO											
(b)													
DUE TO													
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)					
Hour a.m. p.m.		19	While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>										
21. I certify that (I) (this hospital) attended the deceased from.....		1/7, 1962, to.....											
saw the deceased alive on.....		1/7, 1962, and that death occurred at 5:20 P.M. from the causes and on the date stated above.											
22e. SIGNATURE		22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type)		Signature											
23e. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)					
Burial		Jan. 9, 1962		St. Ignatius Cemetery		Hickory, Harford Co., Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR											
Joseph W. Foster		25b. REGISTRAR'S SIGNATURE											
		Date JAN 10 '62											
		Signature											

2071254122



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00695

00690

## 1. PLACE OF DEATH

## a. COUNTY

Harford Maryland

## b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hardey Hall

## c. LENGTH OF STAY IN 1b

77 yrs.

## d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

\_\_\_\_

3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

## 4. SEX

Male

## 6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

6/19/1884

## 9. AGE (In years last birthday)

77 yrs.

10. IF UNDER 1 YEAR  
Months Days Hours Min.

## 11. IF UNDER 24 HRS.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

## 10b. KIND OF BUSINESS OR INDUSTRY

Store

## 11. BIRTHPLACE (County &amp; State, or foreign country)

Harford Co. Md.

## 12. CITIZEN OF WHAT COUNTRY?

U. S. A.

## 13. FATHER'S NAME

Wm. M Commons

## 14. MOTHER'S MAIDEN NAME

Anna M Commons

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

Unknown

## 16. SOCIAL SECURITY NO.

Unknown

## 17. INFORMANT

Wathene W. M Commons

## Address

569 Congress

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

560.5

## DUE TO

Conditions, if any, which  
give rise to immediate cause  
(a), stating the underlying  
cause last.

## (b)

DUE TO

## (c)

Prostate - Multiple Hernia Debility

INTERVAL BETWEEN  
ONSET AND DEATH

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour a.m.  
p.m.20d. INJURY OCCURRED  
While at work  Not While at work 

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

## 20f. (City or town)

## (County)

## (State)

## 19 19

## 21. I certify that (I) (this hospital) attended the deceased from 1/1/60 to 1/26/62, 1960 to 1962, that (I) (we) last saw the deceased alive on 1/26/62, and that death occurred at Hardey Hall, M. from the causes and on the date stated above.

## 22a. SIGNATURE

## ATTENDING PHYS.

MED. DIRECTOR  STAFF PHYS. 

## 22b. DATE SIGNED

## 22c. PHYSICIAN'S NAME (Type)

## M.D.

## 22d. ADDRESS

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

## 23b. DATE THEREOF

## 23c. NAME OF CEMETERY OR CREMATORIUM

## 23d. LOCATION (City, town or county)

## (State)

## Burial 1/29/62

## Angel Hill

## Hardey Hall, Md.

## Md.

## 24. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

## 25a. REC'D BY REGISTRAR

## 25b. REGISTRAR'S SIGNATURE

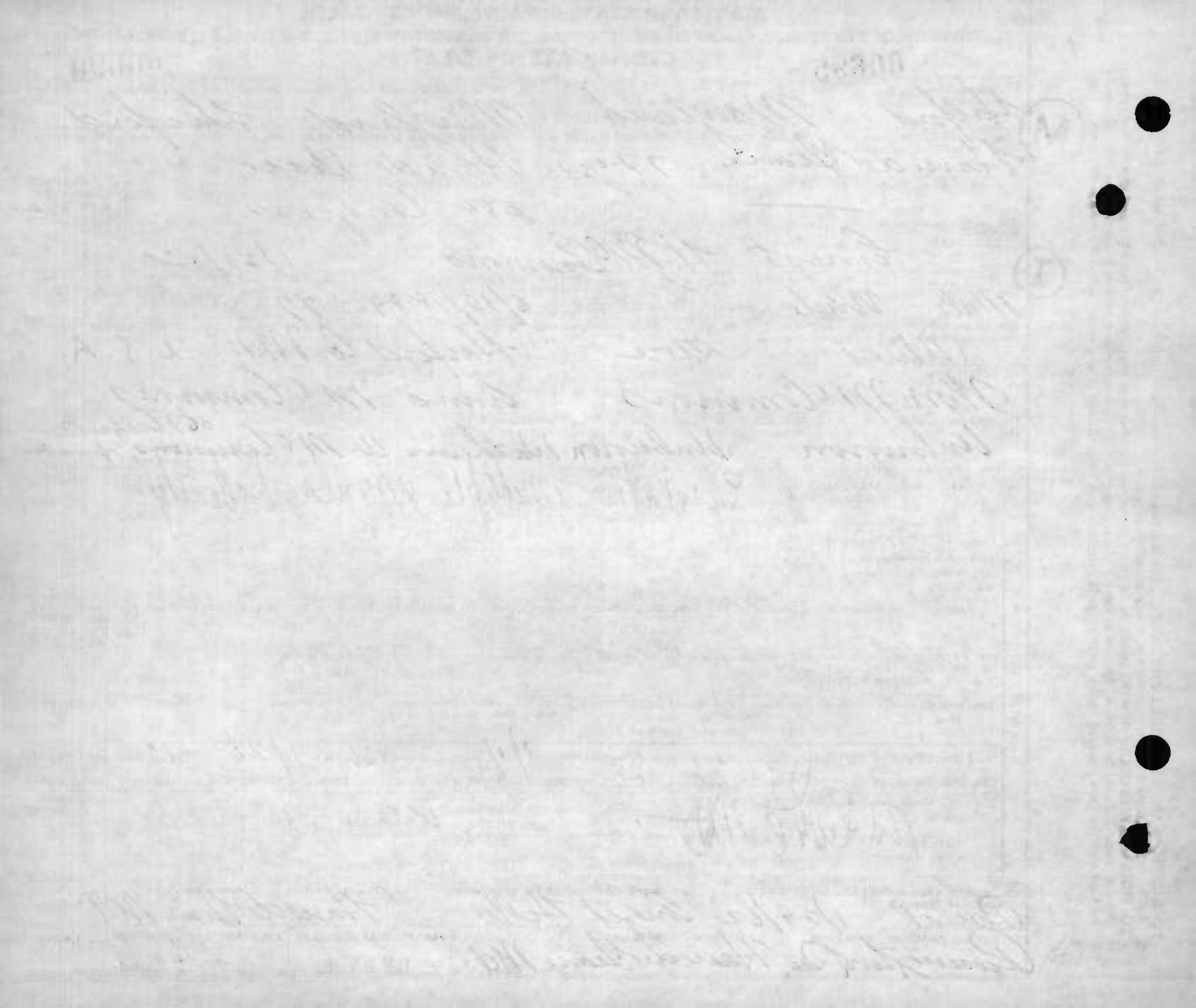
## DATE JAN 31 '62

## Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be made by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

111556 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Carroll MARYLAND		a. STATE Md. Pa. b. COUNTY Hagerstown, York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4227-74 Grace		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hagerstown Memorial Hospital		d. STREET ADDRESS Red Lion 75x-3	
e. NAME OF DECEASED (Type or print) Winfred B. McElwain		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY State Highway Dept.	
13. FATHER'S NAME Cray McElwain		11. BIRTHPLACE (State or foreign country) Fawn Twp., York Co., Pa.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		12. CITIZEN OF WHAT COUNTRY? USA.	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO	
{		DUE TO	
{		(c)	
Coronary occlusion			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bel Air, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Gerald C Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-21-62	
EXAMINER'S NAME (Type) Gerald C Palmer - M.D.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-62	
22c. NAME OF CEMETERY OR CREMATORIAL FAWN GROVE METHOD.		22d. LOCATION (City, town, or country) FAWN GROVE, YORK Co., Pa.	
23. FUNERAL DIRECTOR Kenneth W. Dobson		ADDRESS Stewartstown, Pa.	
24e. REC'D BY REGISTRAR JAN 23 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	
24f. DATE			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00697

## CERTIFICATE OF DEATH

00692

## 1. PLACE OF DEATH

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Havre de Grace

c. LENGTH OF STAY IN 1b

7 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Harford Memorial Hospital

3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

LAURA

J. McNutt

## 5. SEX

F

## 6. COLOR OR RACE

W

MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

## 8. DATE OF BIRTH

Dec. 11 1882

79 yrs.

AGE (in years last birthday)

## 4. DATE OF DEATH

Month

Jan

January

5

1962

Dey

Year

1962

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework at home

## 10b. KIND OF BUSINESS OR INDUSTRY

Harford Co., Md

## 11. BIRTHPLACE (County &amp; State, or foreign country)

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME

Unknown

## 14. MOTHER'S MAIDEN NAME

Unknown

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

No

## 16. SOCIAL SECURITY NO.

No

## 17. INFORMANT

Samuel H. McNutt

Address

Bel Air, Md

## 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (e)

434

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

Pneumonia

Congestive Heart Failure

## INTERVAL BETWEEN ONSET AND DEATH

Today

4 hrs

## 19. WAS AUTOPSY PERFORMED?

YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

## 20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

While at work

Not While at work

## 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

## 21. I certify that (I) (this hospital) attended the deceased from

5 Jan 1962

1961, to

Jan 5, 1962

, that (I) (we) last saw the deceased alive on

5 Jan 1962

and that death occurred at

9:45 A.M.

from the causes and on the date stated above.

July 17, 1961, to Jan 5, 1962

, 1962, that (I) (we) last saw the deceased alive on

5 Jan 1962

and that death occurred at

9:45 A.M.

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5 Jan 1962

and that death occurred at

9:45 A.M.



1  
FOR STATE  
HEALTH DEPT.

M

4

TO DEPUTY  
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
1-29-62 a.m. 00058 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00058 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00058

1. PLACE OF DEATH a. COUNTY		Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		Md		b. COUNTY		Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Fallston		c. LENGTH OF STAY IN lb		12 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Fallston		d. STREET ADDRESS		Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)														e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Joseph		Middle C. J. fford		Last Norris		4. DATE OF DEATH		January 12		Month 1962		Day		Year	
5. SEX		M		W		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days Hours Min.	
										5-8-1898							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Electrician		10b. KIND OF BUSINESS OR INDUSTRY		Construction		11. BIRTHPLACE (State or foreign country)		Forshee Md		12. CITIZEN OF WHAT COUNTRY?		U.S.			
13. FATHER'S NAME		John J. Norris		14. MOTHER'S MAIDEN NAME		Elizabeth Gibney		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
								218-01-1687		Mrs Edward Kelly Sr		Fallsburg, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		422.1		DUE TO		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		Arteriosclerotic C V disease		INTERVAL BETWEEN ONSET AND DEATH					
		Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.		{		(b)											
				{		DUE TO											
				{		(c)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
		19															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Gerald C Palmer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED											
ACTUAL SIGNATURE		Gerald C Palmer		Baltimore, Md													
EXAMINER'S NAME (Type)		Gerald C Palmer, MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		1-12-62											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or country) (State)											
Burial Jan 15, 1962				Baltimore Methodist		Baltimore, Md											
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE											
Arthur S. Kline				JAN 16 '62		Arthur S. Kline											

M

52

1900-1903 1907-8

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE de GRACE</b>		c. LENGTH OF STAY IN 1b <b>App 6 mos</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryman</b>		d. STREET ADDRESS <b>'Mitchell's Cattery</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Memorial Hospital</b>				d. STREET ADDRESS <b>'Mitchell's Cattery</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George</b>	First	Middle	Last	4. DATE OF DEATH Month <b>January</b>	Month	Day <b>22</b>	Year <b>1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>July 9 1888</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Andrew Osborne</b>		14. MOTHER'S MAIDEN NAME <b>Lill Parish</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>EOGAR SHEETS, BELCAMP, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>							
42 2.1   DUE TO <b>et decampansation</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A. S. c. V. D.</b>							
DUE TO <b>Hemiplegia et</b>							
(c) <b>Malnutrition</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>ASH Co.</b>	(County) <b>N.C.</b>	(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/22</b> 19 <b>62</b> to <b>1/22</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1/22</b> 19 <b>63</b> and that death occurred at <b>10:30</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>John</b>		M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JAN. 26, 1962</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>OSBORN PRIVATE CEM</b>		23d. LOCATION (City, town, or county) <b>ASH Co.</b> (State) <b>N.C.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Madison Mitchell HAURE DE GRACE, MD.</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JAN 26 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00700

CERTIFICATE OF DEATH

001695

1. PLACE OF DEATH

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

71  
Havre de Grace

c. LENGTH OF STAY IN 1b

2 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Harford Memorial Hospital

3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month 1 - 17

Year 1962

5. SEX

6. COLOR OR RACE

Male White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

DEC. 23, 1885

9. AGE (In years last birthday)

76 yrs.

10. IF UNDER 1 YEAR

Months 0 Days 0

11. IF UNDER 24 HRS.

Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Painter

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Virginia, Tazewell Co. USA

13. FATHER'S NAME

John Ratcliffe

14. MOTHER'S MAIDEN NAME

Elizabeth Broyles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Dora M. Ratcliffe, Street, Md.

INTERVAL BETWEEN  
ONSET AND DEATH  
3 months.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

42  
Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

DOUE TO

(b)

DOUE TO

(c)

Chronic Cardiac decompensation

Arteriosclerotic Cardiovascular Disease?

0  
MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED?

YES  NO

20a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While

Not While

at work  at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 17th, 1962 to Jan. 17th, 1962 that (I) (we) last saw the deceased alive on Jan. 17th, 1962, and that death occurred at 10 AM, from the causes and on the date stated above.

22a. SIGNATURE

Edward C. Loo, M.D.

M.D.

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

22b. DATE SIGNED

1/18/62

22c. PHYSICIAN'S NAME (Type)

Edward C. Loo, M.D.

22d. ADDRESS

Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

1-20-1962

DEER CREEK

23c. NAME OF CEMETERY OR CREMATORIAL

Forest Hill

(State)

Md.

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

John H. Harbin, Delta, Pa.

25a. REC'D BY REGISTRAR

JAN 22 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

VR A15 (4)  
15M 9/60

6.00

M

220

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00701

## CERTIFICATE OF DEATH

Reg. Dist. No. 011696

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—JOPPA		c. LENGTH OF STAY IN Tb 3 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural—JOPPA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PINE Road		d. STREET ADDRESS PINE Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MICHAEL	Middle JOSEPH	Last REVEL	4. DATE OF DEATH	Month JANUARY	Day 5	Year 1962
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 21, 1949	9. AGE (In years last birthday) 12 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Danbury, Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Burton REVEL				14. MOTHER'S MAIDEN NAME Margaret Mary CREAGHAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Mr. Edward B. REVEL		R.D. #2, Box #64, PINE Road JOPPA, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Spastic paraparesis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT/WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy Not while at work <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Bel Air	(County) (State)
21. I certify that I attended the deceased from 1-1, 1962 to 1-5, 1962, that I last saw the deceased alive on 1-4, 1962, and that death occurred at Bel Air, M.D., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) S. Main St., Bel Air, Md.							
DATE SIGNED 1-5-62							
ACTUAL SIGNATURE Gerald C. Palmer, M.D.							
PHYSICIAN'S NAME (Type)		S. Main St., Bel Air, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF January 8, 1962		22c. NAME OF CEMETERY OR CREMATORIUM St. Francis Cemetery		22d. LOCATION (City, town, or county) Abingdon, Harford Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster		ADDRESS W. Broadway and Williams St. Bel Air, Maryland		24a. REC'D. BY REGISTRAR JAN 8 1962		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	
(Joseph W. Foster)							

CERTIFICATE OF DEATH

06-10-00

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page **3** may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page **3** should be detached for use as the burial-transit permit. Then please remove carbon papers. **1** and **2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00702

**CERTIFICATE OF DEATH**

Item 9 Film G306 3/1/62 iwk

004697

**1. PLACE OF DEATH**

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Aberdeen

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

128 Haw Street

**3. NAME OF DECEASED**  
(Type or print)

First

Middle

Noble Blanche

5. SEX

Female

6. COLOR OR RACE

white

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

June 19-1881

80 yrs.

9. test

Month

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (County & State, or foreign country)

New York

80 yrs.

12. CITIZEN OF WHAT COUNTRY?

USA

**13. FATHER'S NAME**

Elbert J. Walling

**14. MOTHER'S MAIDEN NAME**

Margaret E. Purdy

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give rank or das of service)

200

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs T. Kenneth Miller - Aberdeen, RI 2744

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

200  
Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

DUE TO

(b)

DUE TO

(c)

Cerebral Anoxia,

Generalised Arterio Sclerosis

Diabetes Mellitus

INTERVAL BETWEEN  
ONSET AND DEATH

one year

5 years

MEDICAL CERTIFICATION

**PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)**

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

19

p.m.

20d. INJURY OCCURRED

While at work  Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 19-59, 19....., to Jan. 21....., 19....., that (I) (we) last saw the deceased alive on Jan 20....., 19....., and that death occurred at....., M, from the causes and on the date stated above.

22e. SIGNATURE

Elmer Weiss

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

Jan. 23, 1962

22c. PHYSICIAN'S NAME (Type)

Andre Weiss, M.D.

22d. ADDRESS

114 W. Bel Air Ave. Aberdeen, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial Jan 25-1962

23c. NAME OF CEMETERY OR CREMATORIAL

Bakers Cemetery

23d. LOCATION (City, town or county)

(State)

Aberdeen, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Tarring

Aboriginal Home

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

John G. Tarring - Aberdeen, Maryland

DATE JAN 29 '62

Arthur S. Kraus

卷之三

82

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00703

CERTIFICATE OF DEATH

00698

14  
1. PLACE OF DEATH

a. COUNTY

HARFORD

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Havre de Grace

c. LENGTH OF STAY IN 1b

3 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

HARFORD Memorial Hospital

3. NAME OF  
DECEASED  
(Type or print)

First Middle  
Katherine Helen

4. SEX

Female White

5. COLOR OR RACE

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Wife

10b. KIND OF BUSINESS OR INDUSTRY

None

13. FATHER'S NAME

Patrick Connally

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

e. STATE

Md

b. COUNTY

HARFORD

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Havre de Grace

27

d. STREET ADDRESS

316 Bourbon St

1

e. IS RESIDENCE  
ON A FARM?  
YES  NO

4. DATE  
OF  
DEATH

Leat Smith

Month Day Year  
JANUARY 27 1962

9. AGE (In years  
last birthday)  
81 yrs.

IF UNDER 1 YEAR  
Months Days Hours Min.

12. CITIZEN OF WHAT COUNTRY?  
U.S.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Unknown Mrs Paul Williams

940 Chesapeake Ave

Hanover, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

4221 DUE TO

Conditions, if any, which  
gave rise to immediate cause

(a), stating the underlying  
cause last.

4221 DUE TO

(b)

Arteriosclerotic Cardiovascular  
Disease

(c)

INTERVAL BETWEEN  
ONSET AND DEATH  
1 day

Approx.  
10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

① Chronic bronchial asthma ② Pneumonitis

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from.....

Jan. 21, 1962 to Jan. 27, 1962 that (I) (we) last saw the deceased alive on JANUARY 27, 1962, and that death occurred at 7 A.M. from the causes and on the date stated above.

22a. SIGNATURE

22b. DATE  
SIGNED  
1/27/62

22c. PHYSICIAN'S  
NAME (Type)

ATTENDING  
PHYS.  MED.  
DIRECTOR  STAFF

22d. ADDRESS

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county) (State)

Havre de Grace, Md.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

JAN 31 '62

15M 9/60

20500

M

100  
100

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00704

## CERTIFICATE OF DEATH

Reg. Dist. No. 000699

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>		c. LENGTH OF STAY IN 1b <b>7 yrs.,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>		d. STREET ADDRESS <b>141 Maulsby</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Elva</b>		First <b>V.</b>	Middle <b>Stoots</b>	Last <b>Stoots</b>	4. DATE OF DEATH Month <b>Jan.</b> Day <b>13</b> Year <b>1962</b>	Month <b>Jan.</b>	Day <b>13</b>	Year <b>1962</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan. 30, 1909</b>	9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.,</b>		
13. FATHER'S NAME <b>Arthur E. Snavley</b>			14. MOTHER'S MAIDEN NAME <b>Ollie Steffey</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>228-46-8766</b>		17. INFORMANT <b>Richard J. Stoots</b>		Address <b>Bel Air Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
<p><b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <i>Diffuse metastases to liver - brain, etc.</i> DUE TO <i>Cervix uteri carcinoma</i> INTERVAL BETWEEN ONSET AND DEATH <i>estimate 3-4 mos.</i>          Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>From exact diagnosis - 9 months.</i>          DUE TO (c)</p>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>N/A</i>								
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Bel Air</i>	(County) <i>Bel Air</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <b>3/23/61</b> to <b>1/13/62</b> that I last saw the deceased alive on <b>Jan. 6, 1962</b> , and that death occurred at <b>8:55 PM</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Warren R. Lesch, M.D.</i>				ADDRESS (Street, city or town, state) <b>202 S. Main St., Bel Air Maryland.</b> DATE SIGNED				
PHYSICIAN'S NAME (Type) <b>Warren R. Lesch</b> 202 S. Main St., Bel Air Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>Jan. 15, 1962</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Henderson Funeral Chapel</b>			22d. LOCATION (City, town, or county) <b>Abingdon</b> (State) <b>Virginia.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard K. McComas</i>			ADDRESS <b>Howard K. McComas &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 18 '62</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>		

STATE DEPARTMENT OF HIGHWAYS - ALABAMA

CERTIFICATE OF DEATH

102-121

10

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1130	1131	1132	1133	1134	1135	1136	1137

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00705

**CERTIFICATE OF DEATH**

00705

1. PLACE OF DEATH

e. COUNTY

Harford

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Havre de Grace

c. LENGTH OF STAY IN lb

MARYLAND

9 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Harford Memorial Hospital

3. NAME OF DECEASED  
(Type or print)

MARY MAGGIELEAN

First Middle

#

Last

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Apr. 14, 1899

DATE OF DEATH

Month

Day

Year

January

9

1962

9. AGE (In years  
less birthday)

62 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Inspector

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Govt.

PEOPLES

11. BIRTHPLACE (County & State, or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.,

13. FATHER'S NAME

John Mc Fadden

14. MOTHER'S MAIDEN NAME

Millie Hess

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

218-22-2103

William Taylor

Address

Edgewood Maryland

INTERVAL BETWEEN  
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (e)

4 22. DUE TO  
Conditions, if any, which  
gave rise to immediate cause  
(e), stating the underlying  
cause first.

(b) DUE TO  
Particular 1st day -

(c) DUE TO  
Cholesterol & lithium - Neurofibromatosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While at work  Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at....., from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S  
NAME (Type)

William K. Brendle

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

22b. DATE  
SIGNED

23e. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Jan. 12, 1962

23c. NAME OF CEMETERY OR CREMATORIAL

Bel Air Memorial Gardens

23d. LOCATION (City, town or county) (State)

Bel Air Harford Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Howard K. McComas & Son

25e. ADDRESS

Abingdon Maryland.

25e. REC'D BY REGISTRAR

JAN 15 '62

25b. REGISTRAR'S SIGNATURE

Arthur L. Kraus



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00706

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

111711

1. PLACE OF DEATH

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Shawsville

c. LENGTH OF STAY IN 1b

20 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Bradenbaugh Rd

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED

B. DATE OF BIRTH

M

C

WIDOWED

DIVORCED

Dec 20, 1889

9. AGE (In years  
last birthday)

72 yrs.

IF UNDER 1 YEAR

Months

Deys

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Labored

10b. KIND OF BUSINESS OR INDUSTRY

Farm.

11. BIRTHPLACE (State or foreign country)

Harford Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

George W. Little

14. MOTHER'S MAIDEN NAME

Mary Ellen Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

218-18-7336

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

422

DUE TO

Conditions, if any, which  
give rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Arteriosclerotic CVDisease

INTERVAL BETWEEN  
ONSET AND DEATH

2  
MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING  CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour e.m. 19  
p.m.

20d. INJURY OCCURRED  
While Not While  
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)  
(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Gerald C Palmer  
M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

1-22-61

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

1-25-62

22c. NAME OF CEMETERY OR CREMATORIUM

PINE GROVE CHURCH

22d. LOCATION (City, town, or country)

BALTO. Co., Md.

(State)

23. FUNERAL DIRECTOR

George W. Little F. H.

23b. ADDRESS

230 BALTO. PIKE

24a. REC'D BY REGISTRAR

JAN 24 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Trahan



1  
FOR STATE  
HEALTH DEPT.

please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
item 10 Film 510 4-5-5-7  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00707

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00702

1. PLACE OF DEATH  
a. COUNTY

Harford County

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Harford de Soto

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Harford Memorial Hospital

3. NAME OF  
DECEASED  
(Type or print)

First  
Carl

Middle  
Stanley

Last  
Williams

4. DATE  
OF  
DEATH  
January 23  
1962

5. SEX

male

6. COLOR OR RACE

negro

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

7/9/1960

9. AGE (In years  
last birthday)

16 mo. yrs.

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

none

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Harford Co., Md.,

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.,

13. FATHER'S NAME

Arvelle Williams

14. MOTHER'S MAIDEN NAME

Lillian Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give rank or date of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Lillian Williams

Address

Joppa Maryland.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchopneumonia, Otitis media/acute

INTERVAL BETWEEN  
ONSET AND DEATH

491 X

DUE TO

Conditions, if any, which  
give rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

2  
MEDICAL CERTIFICATION

Otitis media

Cerebral edema

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.

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20c. TIME OF INJURY  
Hour a.m. Month, Day, Year  
p.m. 19

20d. INJURY OCCURRED  
While Not While  
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

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death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
SIGNATURE

Russell S. Fisher

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S  
NAME (Type)

Russell S. Fisher

Address (Street, city, town, or county)

Jan. 24, 1962

22e. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Jan. 27, 1962

22c. NAME OF CEMETERY OR CREMATORIUM

Asbury

22d. LOCATION (City, town, or country)

Loreley, Balto.,

(State)

23. FUNERAL DIRECTOR

Howard K. McComas

McComas & Son

ADDRESS

Abingdon Maryland

24e. REC'D BY REGISTRAR

JAN 30 '62

24b. REGISTRAR'S SIGNATURE

Russell S. Fisher

VS. A15ME  
5M 9/60

16300

M

\VV

1000

100

altitudinal

altitudinal

sampled

sampled

1000

100

1000

1000

biotic factors not sampled